diagnostic groups intervention is of real value. Impaired hearing is the cause most obviously requiring early recognition and expert treatment, but in the other groups speech therapy, nursery or nursery-school placement, and advice and support to the parents will often greatly improve language development and family morale, and they appear to be more effective if started early. Bax's plea for care and attention for the child with delayed speech is entirely correct.

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3 Neligan G, Prudham D. Norms for four standard developmental milestones by sex, social class and place in family. Develop Med Child Neurol 1969;11:413-22.

Auditing the NHS

The National Health Service faces the prospect of stringency compounded by uncertainty for the foreseeable future. Both the stringency and the uncertainty are documented in the latest report from the House of Commons Social Services Committee in its annual review of the Government's expenditure plans.¹ The figures given in the Government's expenditure White Paper,² published in March, implied a 2.5% growth in NHS services during 1982-3, of which 0.4% was to be financed by "efficiency savings." For the following two years the plans implied an annual growth in services of 0.5% to be wholly financed out of "efficiency savings." But the expenditure plans were out of date almost as soon as they were published. The assumptions about likely pay rises, built into the cash limits formula, proved overoptimistic. By the time the Social Services Committee published its report it was clear that the real growth in the current financial year would be less than 2%—assuming that there are no further increases in pay and that the "efficiency savings" do not turn out to be a figment of ministerial imagination. Furthermore, the achievement of even a modest 0.5% growth in services in the subsequent two years depends not only on the required "efficiency savings" but also on a continuing fall in the rate of salary and wage settlements, as envisaged in the Government's cash planning assumptions. So the only certainty would seem to be that the outlook is bleak.

But there is one fundamental problem about interpreting the Government's expenditure plans. This derives, as the Social Services Committee has argued in a series of reports over the years,³ ⁴ from the conventional assumption that the output of the NHS may be equated with the inputs—that is, that spending figures are an adequate proxy for measuring the services provided. It is all too easy to fall into the trap of assuming that extra resources improve the NHS's performance and, conversely, that any cuts automatically imply deteriorating services and standards. The equation is far more complex. On the one hand, demands on the NHS are increasing in line with demographic and other changes. For example, the DHSS reckons that demographic factors—for example, an aging population—increase the demand for health services by 0.6%. On the other hand, the capacity of the NHS to meet any given volume of demand depends not only on the quantity of resources available but, self-evidently, on the way in which they are used. Few people in the NHS would contest the proposition that there is scope for improving the efficiency with which resources are used, though there is invariably sharp disagreement about whose efficiency should be improved. Clinicians emphasise the scope for making savings in managerial costs while administrators emphasise the scope for savings in clinical costs. On the face of it, therefore, the Government's contention that "efficiency savings" can pay for growth in services is reasonable.

The real difficulty lies in finding measures of NHS performance independent of the spending figures. Do "efficiency savings" mean that the same quantity and quality of services are being provided with fewer resources? Or do they mean that money has been saved by reducing the standards and scope of the services being provided? Does the decline in the growth rate of the NHS's budget—a growth rate which, in any case, only reflected a series of ministerial rule-of-thumb decisions about what was affordable—inevitably mean a deterioration in services? Or is it compatible with maintaining the level and quality of provision? None of these questions can be answered without information about change over time in the NHS's capacity for delivering care to patients—some way of relating input to output.

Already in 1980, therefore, the Social Services Committee argued that the DHSS should give high priority to developing a comprehensive information system that would permit this committee and the public to assess the effect of changes in expenditure levels or patterns on the quality and scope of the services provided.⁵ It returned to the same theme in 1981,⁶ when it was also taken up by the Committee of Public Accounts. The latter argued for the development of an information system that would permit the DHSS "to monitor key indicators of performance by the regions." And it returned to the charge in its latest report,⁷ published earlier this year, when once again it emphasised the need for "effective monitoring" by the DHSS.

Parliamentary nagging has had its effect, as the DHSS's evidence to the two committees in 1982 shows. Despite the rhetoric of decentralisation that preceded the 1982 NHS reorganisation, the DHSS is in the process of strengthening central audit of the NHS. Starting this year each regional chairman and his officers have to account for their performance directly and personally to the Secretary of State while, in turn, each district chairman and his officers will have to account for their performance to the region. At the same time, the DHSS is developing new instruments for scrutinising the performance of the NHS. For example, it is launching an experimental management advisory service in several regions, designed to test different approaches to the problems of performance evaluation. It has also set up a working party to examine audit (p 756).

All this activity begs, however, a crucial question—what criteria are going to be used in measuring or auditing the performance of the NHS? The concept of performance is both complex and problematic. The NHS is a heterogeneous organisation pursuing various often ill-defined and sometimes
conflicting objectives. The definition of performance is, therefore, far from self-evident. From the clinical perspective the objective may well be to maximise the care for individual patients. From the managerial perspective the objective may well be to maximise the care for a given population. Different definitions imply different criteria. In turn, different criteria imply different indicators for measuring performance and determine what kinds of information will be used in any audit exercise.

One source of information about the NHS’s performance comes from the DHSS’s programme budget, published as part of the department’s evidence to the Social Services Committee. This sets out NHS expenditure on specific services and client groups, so it is possible to see whether the DHSS is succeeding in matching the flow of resources to its policy objectives. On this criterion the latest evidence is reasonably reassuring. Between 1975 and 1980 the targets set out in the DHSS’s priorities document, The Way Forward,7 were broadly achieved. The average annual growth in spending on the community health services (1-9%) was greater than that on the hospital services (1-3%). The number of acute beds declined according to plan, and the number of obstetric beds fell even faster than planned. The number of health visitors and district nurses rose almost as fast as intended. Only in the case of geriatric bed provision was there a conspicuous failure: provision not only fell short of the planned total but was considerably lower, in relation to the relevant population, than in the mid-’seventies.

The DHSS’s programme budget also provides information about another aspect of performance—the costs of treating different kinds of patients. For example, it shows that during the second half of the ’seventies the average cost of inpatient cases fell by 6% for acute services and 12% for maternity services, while the average cost per day rose by 12% for geriatric patients, 16% for mentally handicapped patients, and nearly 19% for mentally ill patients. Again, this would appear to be in line with the DHSS’s objectives: to increase efficiency in the acute services while improving standards in the hitherto relatively deprived services. But the evidence is ambiguous. Cutting costs per patient treated may be a sign either of increased efficiency or lowered standards; increasing the costs may be a sign either of improved standards or increasing inefficiency. It is therefore difficult to draw any confident conclusions about the NHS’s performance from figures such as these.

In any case, the DHSS’s programme budget tells us a lot about the input of resources, something about the activities of the NHS, but little about the output of the services concerned in terms of their quantitative or qualitative adequacy. The DHSS is therefore now experimenting with a set of “performance indicators” designed to help in the assessment of regional and district health authorities. These represent an attempt to capture at least some of the different dimensions of “performance.” Some of the indicators are familiar measures of cost, such as cost per inpatient standardised for specialty mix. Others are equally familiar measures of throughput, such as the average number of inpatients per bed over the year and the average number of outpatients seen in each clinic session. Yet a further set seeks to measure the adequacy of the services provided by looking at the proportion of all urgent admissions with a delay of more than one month and the proportion of non-urgent admissions with a delay of more than one year.

These, as the DHSS witnesses emphasised in their evidence to the Social Services Committee and to the Committee of Public Accounts, are crude indicators. As Sir Kenneth Stowe, the DHSS’s Permanent Secretary, pointed out, they permit questions to be asked, not conclusions to be drawn. But the DHSS’s indicators should, in turn, provoke questions. Why, for example, are indicators of hospital activity not translated into indicators of services provided for the relevant population? Even using existing data it is possible to compare the performance of districts—and changes over time—in terms of what they provide to whom, how they compare in the number of hips and hernias repaired, and so on.9 No doubt it will be easier to generate such information when the recommendations of the Körner Group on Information10 have been implemented, but much could be done already. Nor do the DHSS’s performance indicators provide any information about standards, though some indications may be drawn from the reports of the Health Advisory Service and the National Development Team for the Mentally Handicapped. Lastly, and perhaps most importantly, the performance indicators tell us nothing about outcome—namely, the effect of NHS activity on mortality, morbidity, and quality of life.

Auditing the performance of the NHS is, clearly, both a conceptual and a technical minefield: the DHSS is not alone in not being able to find or devise outcome indicators. But it is an essential complement to clinical audit. For, in the long run, it will be possible to draw up a balance sheet of the impact of changes in spending levels only by combining indicators of performance that measure productivity and the quantitative adequacy of the services provided with indicators of performance derived from clinical audit that measure the quality and efficacy of care. To concentrate exclusively on the former is to risk encouraging greater productivity at the expense of standards. To concentrate exclusively on the latter is to risk encouraging improvements in standards at the expense of the quantity and scope of the services provided. The new interest in auditing the performance of the NHS is therefore both a challenge and an opportunity for the medical profession to develop systematically and comprehensively its own indicators of performance.

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